UNIVERSITY Physicians @Stony Brook

INITIAL PATIENT INFORMATION

DATE: _____

NAME (PRINT)_____ **DATE OF BIRTH:**_____

PHONE (HOME)_____**(WORK)**_____ **(CELL)**_____

OCCUPATION: _____ **TYPE OF INSURANCE:** _____

DO YOU HAVE PAIN? [ ] YES [ ] NO INTENSITY SCALE: lowest 0 1 2 3 4 5 6 7 8 9 10 highest

WHERE IS THE LOCATION OF YOUR PAIN? _____

HOW LONG HAVE YOU BEEN IN PAIN?_____

DOES ANYTHING YOU DO HELP DECREASE YOUR PAIN? _____

DO YOU TAKE MEDICATIONS OR ANTI-INFLAMMATORIES FOR YOUR PAIN? _____.

If yes, What kind and for how long?_____

HAVE YOU PARTICIPATED IN ANY PHYSICAL THERAPY? [ ] YES [ ] NO.
If yes, for how long?_____.

List in order of importance your main complaints:

1. _____

2. _____

3. _____

WHEN DID THE PROBLEM START? HOW? _____

IS THIS A WORK RELATED ACCIDENT? [ ] YES [ ] NO _____ **DATE:** _____

IF YES, HOW? _____.

WAS AN AUTOMOBILE INVOLVED? [ ] YES [ ] NO DATE: _____

ARE YOU PRESENTLY WORKING? [ ] YES [ ] NO

DATES OF DISABILITY? _____ **to** _____.

DETAIL YOUR TREATMENT AND PROGRESS TO DATE:_____

_____

PAST HISTORY:

Operations: _____

Medical Illnesses: _____

Drug Allergies: _____

Regular Medications: _____

Family Illnesses (parents, grandparents, etc.) _____

Do you drink alcoholic beverages? [ ] YES [ ] NO If yes, how much/how often? _____

Do you smoke? [ ] YES [ ] NO If yes, how much/how long? _____

Did you ever smoke [ ] YES [ ] NO If yes, how long? _____ **When did you quit?** _____

Have you ever had any blood clots? [ ] YES [ ] NO If yes, are you on blood thinners? _____

Does any family member have a history of having a blood clot? _____

Do you have any of the following conditions?:

_____ Stomach Problems	_____Heart Disease	_____ Lung Disease	_____Diabetes
_____ Vessel Disease	_____Cancer	_____ Bleeding	_____Cancer
_____ Kidney Problems	_____Intestinal Disease	_____ Epilepsy	_____Gout
_____ Psychiatric Illness	_____Arthritis	_____ Sexual Difficulties	_____ Blood clots
_____ Bowel or Bladder Problems		_____ Other (please explain):_____	

Do you have any problems with your joints? _____**Hips** _____ **Knees** _____**Ankles**

_____**Feet** _____**Elbows** _____**Wrists** _____**Hands** _____**Shoulders**

Were x-rays taken? [ ] YES [ ] NO **If yes, when?** _____

Name and Address of x-ray Facility? _____

Diagnostic Studies Performed: _____**CT Scan** _____**MRI** _____**EMG** _____**Bone Scan**

Name of Facility where performed: _____

_____ _____

PATIENT SIGNATURE DATE PHYSICIAN SIGNATURE DATE

_____ **I have reviewed the above with the patient.**

_____ **I have reviewed and discussed the above conditions with the patient and have recommended that they follow-up with their medical doctor for care.**

REVISED 6/15/16